HUMAN **S**ERVICE **C**OLLABORATIVE

1728 WISCONSIN AVE., N.W., SUITE 224 WASHINGTON, D.C. 20007 (202) 333-1892 FAX:(202) 333-8217

SHEILA A. PIRES, M.P.A.
IRA S. LOURIE, M.D.
CLIFF DAVIS
KATHY LAZEAR
EARL T. BRAXTON, PH.D.
MARIA ELENA ORREGO

CLIFF DAVIS
10800 SPRINGWATER DRIVE
MT VERNON, OHIO 43050
(740) 397-1915 (VOICE)
(740) 397-1916 (FAX)
EMAIL: CLIFFD1030@AOL.COM

May 8, 2006

Mr. John Selig, Director
Arkansas Department of Health and Human Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, AR 72203

Dear Director Selig:

I am submitting this Arkansas System of Care Plan Framework for your consideration in response to the requirements of Act 2209 of Regular Session, AR 85th G.A., 2005. This document presents a beginning Plan Framework, allowing a more detailed plan to be developed through processes that include all stakeholders in effective services for children with serious emotional disturbances and their families.

With respect, I wish to make several recommendations regarding the presentation and implementation of this Plan Framework.

First, it is essential that DHHS make improving the quality of care for children with serious emotional disturbances and their families a highest priority, reflected clearly in all of your public remarks and with a commitment by all DHHS Division Directors to the collaborative implementation of this Plan. More specifically, I recommend that you make the development of an Arkansas System of Care a Department-wide priority, not simply a mental health initiative, because emotional disturbances among children and adolescents impact the early childhood, child welfare, juvenile justice, education, mental health, substance abuse, developmental disability and Medicaid systems, at a minimum. Without this priority status, System of Care development is likely to become “one more plan” that never comes to fruition.

Second, as you know, there are significant forces standing against System of Care development, and the entire administration, including but not limited to the Department, must be prepared to work with all energy to counter the influence of those forces. I recommend that the Department organize all advocacy resources to present a high-visibility public argument, complete with data and best practice information, to convince Legislators and citizens that Arkansas must improve the quality of mental health care provided to children. Placement into secure treatment facilities is not an effective treatment approach for most children with serious emotional disturbances, while many community and family based interventions are demonstrated to be effective. (See, for example, Burns, B. & Hoagwood, K. (Eds.), (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press.) All Arkansans, from the Legislature to the average citizen, must be educated about best practices, creating a groundswell to implement those best practices on behalf of these children, who otherwise have no voice.

Third, it is important that this initiative not be styled as being “against” anyone. Rather, this initiative should be presented as a collaborative effort to establish a higher quality of care for Arkansas children with serious emotional disturbances and their families, seeking to achieve success where success has been absent.

Fourth, the Department must devise strategies to capture current resources invested in child mental health services and redirect them to more appropriate, community based care strategies. An argument can be made that a fully functioning System of Care will eventually save tax resources, but such savings will only be realized sometime in the future. Current resource levels should enable Arkansas to establish a broad array of effective care approaches at the local level.

I and my partners stand ready to assist Arkansas in this endeavor, should you choose to pursue it. We bring experience over many years and in many communities and states to this work, with a steadfast commitment to improving the publicly-funded care of children with serious emotional disturbances and their families. We know such care can be provided effectively and at a cost that is not burdensome to the public system.

Regardless of your upcoming decisions, it has been a pleasure to meet and work with the many Arkansans who share a commitment to the care of children and families, and we wish you success in the coming months and years.

Respectfully submitted,

Cliff Davis, Partner

ARKANSAS SYSTEM OF CARE
ASSESSMENT AND FRAMEWORK SUMMARY

The Assessment and Framework are offered to the State of Arkansas by Cliff Davis, of the Human Service Collaborative, Washington, D.C., to support development of a System of Care Plan for children with serious emotional disturbances and their families, pursuant to the requirements of H.B. 2535 (Act 2209 of Regular Session, AR 85th G.A., 2005). It is explicitly assumed that over time in-state stakeholders will further develop and implement elements of the System of Care.

In conjunction with Cliff Davis, an inter-agency workgroup crafted the following priorities to guide future planning. These recognize that a System of Care:

- is child- and family-driven, not provider/payment-driven;
- provides accountability for all services and supports;
- tracks a child across systems/services with an integrated data system;
- includes a broad service array, including community-based and non-traditional services and supports;
- channels resources, both human and financial, to follow the child; and
- utilizes strong, effective collaboration across systems/providers.

Aligned with these priorities, the System of Care framework provides priority work areas and recommended strategies to fully develop a System of Care in Arkansas.

A. Build family support. Arkansas will build a foundation of family support and advocacy aimed specifically at issues related to successfully raising children with serious emotional disturbances.

B. Expand local capacity to collaboratively meet children's needs. Arkansas will develop the local capacity of communities to collaboratively manage the care of all children with serious emotional disturbances across all child- and family-serving systems, assuring that services are effective, outcomes are monitored, and managers are accountable to families and to taxpayers.

C. Improve the quality of care. Arkansas will enact a broad Quality Improvement Program aimed at improving the effectiveness of the System of Care. Accountability measures will be designed and implemented to assure the effective and responsible use of public resources for the mental health care of children and their families. Accountability is twofold: the System of Care must demonstrate to children with serious emotional disturbances and those who care about them (parents, family, caregivers, and others) that it is providing effective care to those children; and the System of Care must show taxpayers that it is using limited public resources in the most effective and cost-effective manners possible.

As second tier priorities, Arkansas will also take steps to **D)** develop the mental health workforce; and **E)** enhance linkages with physicians and early childhood providers.

Arkansas System of Care Assessment

"We've been through so many changes, it's hard to find the system."
(quote from Arkansas stakeholder, March 1, 2006)

INTRODUCTION

This Assessment is offered to the State of Arkansas by Cliff Davis, of the Human Service Collaborative, Washington, D.C., as an initial piece in the development of a System of Care for children with serious emotional disturbances and their families, pursuant to the requirements of H.B. 2535 (Act 2209 of Regular Session, AR 85th G.A., 2005). It is explicitly assumed that over time in-state stakeholders will further develop and implement the strategies presented in the accompanying System of Care Plan Framework, thereby increasing their workability and buy-in.

The Arkansas System of Care Assessment is organized around the System of Care Priorities established by an inter-agency workgroup, formed to realize the intent of the Legislative Act. Each priority is shown below underlined and in boldface, numbered from 1 through 6. Under each priority are three boldface, italicized subheadings: ***Best Practices***, which describes how each priority manifests in a well-functioning System of Care (the ideal state); ***Arkansas Strengths***, which briefly summarizes current attributes in Arkansas upon which improvements can be built (the real state); and ***Arkansas Areas of Concern***, which briefly summarizes areas that need to be addressed in Arkansas in order to move towards a well-functioning System of Care for children with mental health needs and their families. The Strengths and Areas of Concern were all developed by the author following a review of recent reports and data, and three days of interviews in Arkansas with prominent system stakeholders.

SYSTEM OF CARE DEFINITION

A definition of a System of Care for children with serious emotional disturbances and their families is offered as the ultimate goal of the strategies presented in the accompanying System of Care Framework.

A System of Care is built upon a foundation of shared commitment by all relevant stakeholders (e.g., children, caregivers, service providers, advocates, managers, judges, community members, etc.) to effective, community based care for children with identifiable and treatable emotional disturbances. A System of Care is managed and operates as a system, employing operational linkages between all involved community entities in order to collaboratively address the challenging needs of some children. A System of Care functions to keep children with such challenging needs in their home, in their school, and in their community, guided by the caregivers of such children and ensuring safety for everyone, including the child and all community members.

Every observation in this Assessment lays a foundation for achieving a System of Care across the State of Arkansas.

THE ARKANSAS SYSTEM OF CARE ASSESSMENT

As stated in the Introduction, the following System of Care Priorities (1 – 6) were established by an inter-agency workgroup to guide development of the System of Care. The definitions (Best Practices), Strengths and Areas of Concern were developed by the author.

1. A System of Care is child- and family-driven, not provider/payment-driven.

Best Practices:
Mental health services and supports are accessible at the local level, whether accessed through schools, health or mental health providers, child protection, juvenile justice (including law enforcement), or self-referral. Parents and primary caregivers are viewed as experts about their children and exert final choices about the types and providers of services to be delivered. Standardized, comprehensive mental health assessments are conducted, when indicated, before service planning, and collect key information to guide entrance into the System of Care. Service planning processes identify child and family strengths and match flexible services and supports to those strengths to address child and family needs. Child and family feedback is elicited and constantly used to adjust services and supports, aimed at maximizing positive service impact on the child's functioning and well-being. Service providers are paid on the basis of work performed, with incentives to implement evidence-based practices and flexible services, responsive to each child and family's unique characteristics. Service providers are evaluated on the basis of child and family outcomes attained by their interventions.

Arkansas Strengths:
- Stakeholders appear to share a commitment to providing the best possible care to Arkansas children with mental health needs and their families.
- Public and private service providers share a commitment to implement best practices to care for each child and family in need.
- Arkansas Advocates for Children & Families appears to be a well-respected advocacy organization for appropriate care of children with special needs, and is beginning to engage in work to improve care for this special population.
- NAMI-Arkansas has a new director with experience in children's issues and commitment to advocacy on behalf of children with mental health needs and their families.

***Arkansas Areas of Concern*:**
- Family advocacy and support are poorly developed at the State level, and are invisible in most Arkansas communities. Few parents are involved in system decision-making.
- No mechanism currently exists to involve youth receiving mental health services in the decision-making processes within the mental health system.
- Parents and caregivers of children receiving system services generally do not believe that service providers pay attention to their input about their children's needs.
- Some stakeholders perceive that certain providers decide what services to provide by what can be paid through Medicaid (RSPMI), rather than by what children and families need.
- Current system operations (RSPMI) include no mechanisms for accountability to families about the outcomes obtained or family satisfaction with services and supports.

- Some stakeholders report that children with mental health needs are being processed through the juvenile justice system because they cannot access needed services through the existing mental health system.
- The Arkansas Medicaid system, unlike many other states, appears to carry the bulk of the cost of child mental health care across multiple systems, including education, child welfare and juvenile justice. Because those systems can access Medicaid, there is no incentive to manage overall spending or services purchased (e.g., bed-based vs. community based).
- APS data show that only 6% of outpatient expenditures are for family therapy; services for children should routinely include family/caregiver participation. Data also show that 65% of the children receiving RSPMI mental health services do not receive any family therapy as an element of their care.

2. A System of Care provides accountability for all services and supports.

Best Practices:
System managers at all levels, from State policy development to local service management, know what is being delivered, how it is delivered, by whom, to whom, with what impact, and at what cost, and are able to report all of that information regularly to customers and taxpayers. Services are well-defined, enabling consumers and system agents to compare services received to those definitions. Utilization management (UM) tools help to identify service practices that are at variance with expectations and/or best practices by focusing on outliers, to expand emerging best practices and to rein in or eliminate services of poor quality. Families and children are routinely asked about their experiences receiving services or supports, and their feedback meaningfully impacts service practices. Systems are committed to achieving functional improvements for children with serious emotional disturbances, using specific mechanisms to identify and rectify any failures to improve. Accountability extends uniformly across all categorical services, including but not limited to health, behavioral health (mental health and substance abuse treatment), education, developmental disabilities, child protection, and juvenile justice.

***Arkansas Strengths*:**
- State agencies have assembled meaningful cross-system data about mental health services provided to children and their cost.
- APS, under a contract to manage mental health services, has gathered substantial and significant data describing recent historical usage of Medicaid-paid services.
- Stakeholders appear to share a belief that accountability, to the children and families served and to Arkansas taxpayers, is an important element of a successful system.
- Agreement has recently been reached between the DHHS Divisions of Medicaid and Behavioral Health Services to transfer some management responsibilities for Medicaid-funded behavioral health services to DBHS, creating the opportunity for the entity with behavioral health expertise to increase Medicaid-funded behavioral health service oversight.
- The Early Childhood Mental Health Initiative that includes a UAMS research component is leading to improved understanding and use of service outcome methodologies.
- A Single Point of Entry methodology has been implemented in five mental health catchment areas for children in the custody of DCFS as a demonstration project. As designed, this methodology may provide the basis for broader management of all placements into treatment facilities, ensuring that less restrictive alternative services

that appropriately meet the child's needs are considered first. Evaluation of this demonstration project is currently in process.

- DBHS has developed a statewide consumer satisfaction survey for persons receiving services from community mental health centers which has been tested and will soon be ready for statewide use.
- Community mental health centers and private mental health service providers have stated a collective willingness to comply with service guidelines and effective care target goals.

***Arkansas Areas of Concern*:**

- Children's mental health services are delivered in a scattered way in many public systems, including at least the education, behavioral health, child welfare, juvenile justice and developmental disability systems, but no entity holds oversight responsibilities crossing those systems' funding and regulatory boundaries. This absence of integrated oversight leads to fragmented management and delivery of mental health services to children and their families.
- Current operation of the RSPMI program lacks any viable accountability mechanisms (e.g., services are not defined, well-defined standards for providers of mental health services are not in place, retrospective service reviews are not conducted, outcomes are not documented, and no mechanisms for reconciliation or recoupment are in place).
- Some stakeholders report that providers benefiting financially from an unregulated RSPMI system have successfully lobbied the Legislature to block regulatory strategies.
- There is no standard format or required content for written plans of care.
- No methods of monitoring outcomes obtained through mental health services are implemented on a system-wide or statewide basis.
- There is currently no statewide data set describing consumer and family satisfaction with their experiences in receiving services.
- Decisions to place children into bed-based treatment facilities are made too often by judges who have adopted the practice of ordering children to specific facilities. With all due respect, judges are generally not qualified decision-makers about children's mental health treatment, but they are hampered by an absence of timely mental health assessments and related treatment recommendations.
- Further, it was reported that employees of certain private facilities sit in local courts, offering free assessments that result in every child being placed in the facility for which they work. These assessments are not standardized or regulated in any way.
- No entity or organization holds local responsibility to coordinate mental health care for a child with serious and complex needs. CASSP Coordinating Teams are successful in this role in a few catchment areas where local leaders support the process, but success is uneven and absent in most Arkansas catchment areas.

3. A System of Care tracks a child across systems/services with an integrated data system.

Best Practices:

Any child may require care in more than one child-serving system, and information collected in one system is accessible to others (within privacy requirements), reducing duplication of evaluations and services, while increasing overall coordination of services for each individual child and family. System information about care (e.g., service type, provider, cost, and

outcome) is maintained in aggregate form, allowing system managers to track system indicators in real time and adjust ongoing management and allocation of resources. A true System of Care is best managed by system decision-makers with real-time information about system performance and recipient experience.

***Arkansas Strengths*:**

- Each of Arkansas' child- and family-serving systems appears to recognize the importance of data to effective management of finite care resources.
- Each system's capacity to gather and utilize data appears to be increasing.
- Arkansas already has data frameworks in place that may serve as the foundation for an integrated, cross-system data management system and, with most systems managed under the DHHS umbrella, the building of an integrated MIS system is feasible.
- The DHHS Division of Health has offered to use its statistical data management system as a core upon which to build broader data management across divisions.
- A functional Medicaid system provides PCPs with annual reports listing all enrolled patients and the Medicaid-paid services they received in the past year, thus informing PCPs in their role as the coordinator of patient care.

***Arkansas Areas of Concern*:**

- An integrated (across all child- and family-serving systems) data management system is not currently in place.
- System-level management decisions across all child- and family-serving systems are now routinely made in the absence of system data.
- Data are not readily available to the Legislature in its deliberative processes that impact the functioning of each child- and family-serving system.
- Local courts and DYS report an inability to access assessment and treatment records of youth in current or past mental health care.
- Many stakeholders report that children and adolescents returning to their community following inpatient or residential treatment come without records or discharge plans.

4. A System of Care includes a broad service array, including community-based and non-traditional services and supports.

Best Practices:

A child or adolescent with a serious emotional disturbance and his/her family have access to a range of service and support options, primarily within their home community. Communities offer immediate services, such as counseling, as well as more intensive services, such as crisis intervention, case management, intensive outpatient, day treatment, and school- and home-based services, with intent to prevent institutional services. Acute hospital and intensive residential treatment services are accessible across the State for all youth who need those environments, and step-down services are available to help such youth leave restrictive settings as soon as clinically possible. Therapeutic group homes, therapeutic foster care, and intensive home supports are available to aid the step-down process or to prevent bed-based placements from ever taking place. Wraparound community support teams, built uniquely around each child and family, are structured and supported by categorical systems operating collaboratively, with access to flexible resources.

***Arkansas Strengths*:**

- In SFY05, Medicaid data indicate that mental health services were provided to 51,336 Arkansas youth under age of 21, representing approximately 7% of the Arkansas population in this age group. A substantial portion of that group received very small amounts of mental health services (suggesting either non-serious treatment needs or an inadequate response to more serious needs).
- Many system-of-care services are in place somewhere within the State, although lacking adequate capacity and with uneven distribution across the State.
- Increasing numbers of stakeholders are embracing the importance of community based services for children and their families.
- Many pilot programs have supported the development of specialized system-of-care services in certain areas, including school-based, early childhood, day treatment, and therapeutic foster care services.
- Arkansas was recently awarded (October 2005) a Federal grant under the Children's Mental Health Services Initiative (ACTION for Kids Project) to be implemented in Craighead, Lee, Mississippi, and Phillips Counties. This project will bring national technical assistance into the State, and it provides an opportunity to demonstrate the effectiveness of the System of Care model at the community level, working within the Arkansas environment.
- The child protection system is preparing to implement team case planning methodologies, with potential applicability across all child-serving systems. Team case planning, or a similar care planning approach, is central to an effective System of Care for children with serious emotional disturbances, whether in custody of DCFS or in family homes.
- Services are currently structured so that trained paraprofessionals can deliver certain mental health services, thus extending the potential pool of workers (see related concern immediately below).
- The Department of Education and DBHS have partnered to support pilot programming for school-based mental health services, including a built-in requirement to expend 30% of the related resources for prevention activities.

***Arkansas Areas of Concern*:**

- Numbers of Arkansas children and adolescents placed in acute inpatient or residential treatment beds for care (5,154 in SFY05 had claims paid for inpatient psychiatric treatment out of 446,747 Medicaid-eligible minors in AR) are extremely high (compared to other states), and the reported average lengths of stay (acute: 10 days; residential treatment: 6-8 months) are extremely long (compared to best practice). Many stakeholders report that many children are "cycling" in and out of these placements as a consequence of inadequate follow-up in the community when children are released from bed-based care.
- Transportation of children and families to service/provider agencies is challenging and unreliable, more so in the most rural areas.
- There are reported needs for increased care capacity for special populations, including at least: foster children; youth involved in the juvenile justice system; sexual offenders; and, youth dually diagnosed with mental health needs and developmental disabilities.
- Very few services are available to treat Arkansas youth with substance use disorders.
- The RSPMI program lacks requirements for the intensive community based services known to be effective for children with serious emotional disturbances. The absence of intensive treatment options contributes to the high Arkansas utilization of bed-based care.

- Some stakeholders report that certain providers accept only low-need, Medicaid eligible clients in order to maximize billing and minimize service need (known as "creaming"), leaving other providers to serve children with more serious needs and children without payment resources.
- Arkansas has a growing population of persons from Hispanic cultures, but there are few to no bi-lingual mental health service providers among the publicly-paid treatment agencies.
- APS data show that 32% of outpatient service billing buys mental health services delivered by paraprofessionals. While no standard exists, this proportion suggests a high degree of non-professional mental health services, with no tools to monitor quality or impact.

5. A System of Care channels resources, both human and financial, to follow the child.

Best Practices:
Managers at the highest levels know enough about what is happening within their systems to adjust resource deployment on an ongoing basis, driven by current (real time) demands on the system. Funding sources are invisible to children and their families, while system managers assure that all appropriate funding streams are fully applied, maximizing federal dollars and ensuring the most cost-effective use of state and local (discretionary) dollars. Services received by children and their families are exclusively driven by the needs those children and families present to the system, and non-traditional and informal services are accessible within the community. Systems manage human resources to ensure a steady pool of qualified personnel for service-providing agencies, including pre-service preparation (through partnerships with institutions of higher learning and pre-practice training requirements) and in-service training (promoting best practices within and across categorical systems).

***Arkansas Strengths*:**
- Basic understanding of the current resources invested in child mental health services is held across all child- and family-serving systems.
- Specific mental health workforce needs have been identified within several child-serving systems (at least mental health, child welfare, and education).

***Arkansas Areas of Concern*:**
- There is a lack of qualified professional staff, both in rural settings and for several types of mental health specialties (e.g., child-trained psychiatrists).
- Generally speaking, higher education institutions in Arkansas are not involved in a planned effort to prepare persons to work in a mental health system-of-care approach.
- Many stakeholders report that children leaving residential treatment or acute hospital facilities are frequently not receiving adequate follow-up care in the community, leading to patterns of re-entry to bed-based care ("cycling"). This is a direct consequence of the Arkansas practice of declaring a child placed by court order in an inpatient program as a Medicaid-eligible "family of one", regardless of family eligibility for Medicaid coverage. When the child leaves placement, the entire family must meet eligibility criteria to receive community-based care.
- The sharp funding division between "inpatient" and "outpatient" mental health services appears to contribute to problems in obtaining follow-up services in the community.
- Minimal funding exists to support non-traditional, informal, wraparound-type services and supports for children and their families.

- The Licensed Professional Counselor Board has not established reciprocity agreements with other states, hindering recruitment of out-of-state, licensed professionals to work in Arkansas.

6. A System of Care utilizes strong, effective collaboration across systems/providers.

Best Practices:
Behavioral health services (mental health and substance abuse treatment) are implemented across many discrete systems, including but not limited to the health, behavioral health, education, child protection, developmental disability, and juvenile justice systems. All policy, funding, management, and evaluation processes for behavioral health services involve active negotiation between those systems, along with families and youth and their advocates. The State behavioral health system managers ensure collaborative involvement by all stakeholders. A local infrastructure is established, in all Arkansas communities, to ensure shared decision-making about local resources and processes. All service providers, of all types, have representation in decision-making processes, to the extent they wish to be represented. Family members and/or family advocates are partners in all system collaboration, ensuring fidelity to family voice.

***Arkansas Strengths*:**
- The CASSP Coordinating Council and the inter-agency workgroup provide statewide leadership in collaboration.
- Most of the major child-serving systems (health, developmental disabilities, mental health, substance abuse, child welfare and juvenile justice) are managed within the Arkansas Department of Health and Human Services, offering a clear administrative opportunity to promote collaborative planning and implementation across those systems.
- Regional CASSP Councils might provide an existing infrastructure upon which to build localized planning and development for the System of Care.
- In the past five years, several interagency groups have studied the child mental health system and made meaningful recommendations for changes/improvements (e.g., the Foster Child Mental Health Collaborative (2002)).
- A strong collaboration between DBHS, the Division of Child Care and Early Childhood Education, the Arkansas Head Start State Collaboration and the University of Arkansas for Medical Sciences is developing and evaluating models of early childhood mental health care, in conjunction with child care and Head Start programming.
- Federally Qualified Health Clinics are collaborating with mental health providers to place mental health professionals in the clinics to employ telemedicine strategies, to increase access to expertise, and to educate medical professionals about depression.
- A partnership between mental health and education has led to grant-funded pilot projects for school-based mental health services and a functional articulation of requirements that assure quality and accountability in those services (e.g., outcome monitoring requirements in school-based mental health provider certification policies).

***Arkansas Areas of Concern*:**
- The consistency in quality and effectiveness of CASSP Regional Councils and local service teams varies significantly. These cross-system entities were established with a mandate to implement wraparound planning process but they were not adequately funded to create the infrastructure necessary to maintain a multi-agency/stakeholder approach to local planning and provision of services and no monitoring for compliance with the mandate is in place.

- Most of the categorical child- and family-serving systems in Arkansas operate independently of one another.
- Families are not as involved in system decision-making in any way, at any level.
- Many stakeholders report that certain providers are entering exclusivity contracts with school districts, requiring that children already receiving mental health care elsewhere withdraw from prior service relationships to enter exclusive care with that specific provider.
- Arkansas stakeholders appear to believe that the helping systems contain many stark divisions, as they frequently employ “we-they” language to describe system functions and problems, rarely describing collaborative approaches to system improvements.

Arkansas System of Care Plan Framework

This Arkansas System of Care Plan Framework is offered to the State of Arkansas by Cliff Davis, Partner, Human Service Collaborative (HSC), Washington, D.C., in response to Act 2209 of Regular Session, AR 85th G.A., 2005, which required the development of a System of Care Plan for serving children with serious emotional disturbances and their families. *This Framework explicitly assumes over time in-state stakeholders will further develop and implement the strategies presented below, thereby increasing their workability and buy-in.*

The Framework is divided into two parts. The First Priority Major Work Areas (A, B, & C) describe major actions needed both first and urgently. The Second Priority Work Areas (D & E) outline actions that are necessary to system-of-care development but that do not carry the same level of urgency for successful system development.

Each Work Area (A – E) is explained within several sections:

1) System of Care Rationale, designed to articulate why this Priority Work Area is important to system-of-care development;
2) Why This Is a Priority for Arkansas, presenting bulleted points (taken from the Arkansas System of Care Assessment, also by HSC) that describe Arkansas strengths to build upon and areas to address in Arkansas in this Priority Work Area; and
3) Recommended strategies.

It must be noted that *this document is not a fully developed System of Care Plan*. Much work must be done by planners and managers within DHHS, in concert with all stakeholders with an interest in the care of children with serious emotional disturbances and their families, to flesh out the specific actions that will further system-of-care development in Arkansas. The fruits of the work described in this Plan Framework may take several years to manifest in improved care for these children; building an effective care system is a complex, time-consuming process. Finally, this overview does not detail the specific action steps that accompany recommendations. Those specifics can be made available at your request and provide a roadmap for designing and implementing a plan that reflects broad stakeholder input.

FIRST PRIORITY MAJOR WORK AREAS (A – C)

First Priority Major Work Areas (A, B, & C) outline major actions needed both first and urgently.

A. Build Family Support. *Arkansas will begin immediately to build a foundation of family support and advocacy aimed specifically at issues related to successfully raising children with serious emotional disturbances.*

1) System of Care Rationale: The System of Care approach, at its heart, is driven by a commitment to recognize parents/caregivers of children with serious emotional disturbances (SED) as the primary resource and best expert for their child, NOT the cause of the child's special needs. Most parents of children with SED intensely love their children and have spent years trying to overcome the challenges presented by the disturbances afflicting their children before asking the system for help. However, Arkansas parents have never been empowered to advocate on behalf of their children and have therefore become dependent on

whatever the system offers, whether it is best for their children or not. Parents deserve to know what has been learned about effective care in other states/communities, giving them hope that their children may be effectively treated within their homes, schools and communities. When children require treatment in a more intensive environment outside their community, it is essential that all helpers, at the facility and in their community, remain dedicated to nurturing the bond between the child and his/her family, aiming towards reuniting the family unit, whenever possible.

2) Why This Is a Priority for Arkansas

- Stakeholders appear to share a commitment to providing the best possible care for Arkansas children with mental health needs and their families.
- Family advocacy and support are poorly developed at the State level and are invisible in most Arkansas communities. Few parents are involved in system decision-making.
- Parents and caregivers of children receiving system services generally do not believe that service providers pay attention to their input about their children's needs.
- APS data show that only 6% of outpatient expenditures purchase family therapy. Data also show that 65% of the children receiving RSPMI mental health services do not receive any family therapy as an element of their care. Services for children should routinely include family/caregiver participation, including therapies and other supports.
- Arkansas is one of the few states without a statewide advocacy organization that is run by parents of children with SED (e.g., the Federation of Families for Children's Mental Health) and dedicated to the development of an effective system-of-care approach.

3) **Recommended strategies to build family support:**

- ❖ Work with existing advocacy organizations to create a Family Advocacy and Support Development Plan by Fall 2006;
- ❖ Establish an Arkansas Family Leadership Training Academy by January 2007;
- ❖ Use all DHHS Division resources to establish and maintain family support groups across the State by Fall 2006;
- ❖ Conduct Family Forums across the State to obtain input from the persons who care for and about children with serious emotional disturbances by Fall 2006;
- ❖ Implement the Consumer Satisfaction Survey currently being tested by September 2006;
- ❖ Establish a clearly defined Peer Advocacy Service, reimbursable under Medicaid, enabling parent paraprofessionals to assist each other;
- ❖ Statewide training for publicly-funded helpers to develop competencies in forming effective partnerships with parents and other caregivers; and
- ❖ Encourage and promote child and family rights and advocacy by all citizens.

B. Expand local capacity to collaboratively meet children's needs*. Arkansas will develop the local capacity of communities to collaboratively manage the care of all*

children with serious emotional disturbances across all child- and family-serving systems, assuring that services are effective, outcomes are monitored, and managers are accountable to families and to taxpayers.

1) System of Care Rationale

Local management of care planning and delivery is an important tenant of the System of Care approach. Local decision-making requires a deliberate infrastructure involving all child- and family-serving systems, in partnership with parents and advocates, to plan, implement and monitor all system-of-care activities. Stated more broadly, care management is the most critical element in successful care for children with the most complex and severe needs, ensuring that children are served appropriately within their home and community, whenever possible. Care management mechanisms must be employed locally to ensure the successful implementation of many different care functions, including: 1) identification of children needing system care; 2) admission to the intensive care system; 3) initial and ongoing assessment/diagnosis of serious emotional disturbances; 4) care planning; 5) service design and implementation; 6) monitoring of care; and 7) use of outcome-based evaluation information to constantly improve system performance.

2) Why This Is a Priority for Arkansas

- Too many Arkansas children are being placed into acute hospital and residential treatment environments because of behavioral health disturbances that could be more effectively treated in community based settings, if such services and supports were available. Numbers of Arkansas children and adolescents placed in acute inpatient or residential treatment beds for care (5,154 in SFY05 had claims paid for inpatient psychiatric treatment out of 446,747 Medicaid-eligible minors in AR) are extremely high (compared to other states), and the reported average lengths of stay (APS data – acute: 10 days; residential treatment: 6-8 months) are extremely long (compared to other states). Many stakeholders report that many children are "cycling" in and out of these placements due to inadequate follow-up in the community upon discharge, with some children reportedly experiencing up to 35 placements.
- Children's mental health services are delivered in a scattered way in many public systems, including at least the education, behavioral health, child welfare, juvenile justice and developmental disability systems, but no entity holds oversight responsibilities crossing those systems' funding and regulatory boundaries. This absence of integrated statewide oversight leads to fragmented local management and delivery of mental health services to children and their families.
- No entity or organization holds local responsibility to coordinate mental health care for a child with serious and complex needs. The consistency in quality and effectiveness of CASSP regional planning teams and local service teams varies significantly. These cross-system entities were established with a mandate to implement wraparound planning process but were not adequately funded to create the infrastructure necessary to maintain a multi-agency/stakeholder approach to local planning and provision of services.
- A Single Point of Entry methodology has been implemented in five mental health catchment areas for children in the custody of DCFS as a demonstration project. As designed, this methodology may provide the basis for managing all placements into treatment facilities, ensuring that less restrictive alternative services that would appropriately meet the child's needs are considered. Evaluation of this demonstration project is currently in process.

- Decisions to place children into bed-based treatment facilities are made too often by judges who have adopted the practice of ordering children to specific facilities. With all due respect, judges are generally not qualified decision-makers about children's mental health treatment, but they are hampered by an absence of timely mental health assessments and the resulting treatment recommendations.
- Most of the categorical child- and family-serving systems in Arkansas operate independent of one another.
- The RSPMI program lacks requirements for the intensive community based services known to be effective for children with serious emotional disturbances. The absence of intensive community treatment options across Arkansas contributes to the high utilization of bed-based care.

3) **Recommended strategies to expand local capacity:**

- ❖ Design and implement a stakeholder planning process to create local care management capacity (by Fall 2006), including the development of rules for such care management (by March 2007), implementation through an initial set of pilot communities (by July 2008), and eventual expansion to all locales within Arkansas;
- ❖ The Governor appoints a State Interagency Management Council (SIMC), and rules are promulgated to establish Local Interagency Management Councils (LIMC), beginning with the care management pilot communities by June 2007;
- ❖ Submit application to CMS for one of the 1915c home and community based waivers authorized under the recent Federal Deficit Reduction Act by Summer 2006;
- ❖ Expand the State Medicaid Plan to include clearly defined community based intensive services for children with serious emotional disturbances by January 2007;
- ❖ Define, train and implement a standardized assessment approach to identify children with mental health needs, regardless of the door by which they and their families enter the helping system between January and June 2007;
- ❖ Establish service provider networks around the local care management entity, including standardized contracting, provider certification, and minimum mandatory service levels for essential services and supports;
- ❖ Develop capacity in evidence-based practices;
- ❖ Integrate current collaborative strategies, such as Together We Can, CASSP Councils, and Multidisciplinary Teams;
- ❖ Place independent mental health assessors into juvenile courts and provide intensive education for judges and court staff around child mental health disturbances;
- ❖ Establish clear discharge criteria for all children placed in institutional care as a result of their need for intensive mental health treatment; and
- ❖ Explore the need for specialized interventions for children from minority populations, especially those with English as a second language.

C. Improve the quality of care. *Arkansas will enact a broad Quality Improvement Program aimed at improving the effectiveness of the System of Care. Accountability measures will be designed and implemented to assure the effective and responsible use of public resources for the mental health care of children and their families.*

Accountability is twofold: the System of Care must demonstrate to children with serious emotional disturbances and those who care about them (parents, family, caregivers, and others) that it is providing effective care to those children; and the System of Care must show taxpayers that it is using limited public resources in the most effective and cost-effective manners possible.

1) System of Care Rationale

The highest level of system accountability is directed towards the care of each child experiencing a serious emotional disturbance. The System of Care must demonstrate that it is doing the best it can to address the challenges of each child's disturbance, leading to appropriate child development and increasing each child's best chance to arrive at adulthood as a productive, functioning member of society. This includes utilizing all that is known about evidence-based practices in the field. The next level of accountability is to the parents/caregivers of those children, including them in all processes and demonstrating effectiveness through outcome and satisfaction measures. The final level of accountability is demonstrating to the taxpayers that public dollars are applied in the most clinically-effective and cost-effective ways possible. The System of Care approach demands that system entry, care planning and delivery, and care monitoring strategies be implemented in ways that constantly feed management information to those charged with management decision-making.

2) Why This Is a Priority for Arkansas

- Public and private service providers in Arkansas appear to share a commitment to implement best practices in caring for each child and family in need.
- Stakeholders appear to share a belief that accountability, to the children served and to Arkansas taxpayers, is an important element of a successful service system.
- Current system operations (RSPMI) include no family accountability mechanisms monitoring the outcomes obtained or family satisfaction with services and supports.
- The RSPMI program currently lacks viable operations accountability mechanisms (e.g., recipients are not certified as high need, services are not defined, well-defined standards for providers of mental health services are not in place, retrospective certification or service reviews are not conducted, outcomes are not documented, and no mechanisms for reconciliation or recoupment are in place).
- Many stakeholders report that children leaving residential treatment or acute hospital facilities are frequently not receiving adequate follow-up care in the community, leading to patterns of re-entry to bed-based care ("cycling"). This is a direct consequence of the Arkansas practice of declaring a child placed by court order in an inpatient program as a Medicaid-eligible "family of one", regardless of family eligibility for Medicaid coverage. When the child leaves placement, the entire family must meet eligibility criteria to receive community-based care.
- No methods of monitoring outcomes obtained through mental health services are implemented on a system-wide or statewide basis.
- System-level management decisions across all child- and family-serving systems are now routinely made in the absence of system data.
- Data are not readily available to the Legislature in its deliberative processes where decisions are made that impact the functioning of each child- and family-serving system.

3) Recommended strategies to improve care quality:

- ❖ Further develop the definition of serious emotional disturbances (SED) among children and adolescents, with a retrospective review process to assure that children with the most serious needs are being identified and treated by October 2006;
- ❖ Develop clear service definitions for all system-of-care services, especially those reimbursed through Medicaid during Fall 2006;
- ❖ Educate legislators and the general public about best practices within the child mental health field between January and March 2007;
- ❖ Promulgate rules utilizing the new service definitions;
- ❖ Promulgate provider certification standards requiring best practices by April 2007;
- ❖ Develop a comprehensive outcomes monitoring system that will enable system managers and taxpayers to understand exactly what services and impact are being purchased by public funds;
- ❖ Retrospective service reviews re-established to ensure appropriate delivery of care; and
- ❖ Develop an integrated management information system across all child- and family-serving systems.

SECOND PRIORITY MAJOR WORK AREAS

The following (D & E) describe major actions that are necessary to system-of-care development but that do not carry the same level of urgency as A through C for successful system development.

D. Develop the mental health workforce. *Arkansas will plan ahead for the workforce needs of the children's mental health system, develop effective training partnerships with the State's professional schools, assure pre-service preparation in the principles associated with effective systems of care, and maintain system competencies in all evidence-based and best practices. Cultural competence will require an enhanced emphasis in all workforce activities.*

1) System of Care Rationale

Working in any role within the System of Care requires preparation to operate in alignment with the fundamental philosophies and support for on-going skill development. Evidence-based practices have been developed in the children's mental health field and all require high degrees of training and supervisory support to implement. Preparation and skill development require partnerships between the System of Care management infrastructure and the State's institutions of higher education, including relevant professional schools, to implement mechanisms that can manage the process.

2) Why This Is a Priority for Arkansas

- Many system-of-care services are in place somewhere within the State, although lacking adequate capacity and with uneven distribution across the State.
- Services are currently structured so that trained paraprofessionals can deliver certain mental health services, thus extending the potential pool of workers.

- There are reported needs for increased care capacity to serve special populations, including at least: foster children; youth involved in the juvenile justice system; sexual offenders; and youth dually diagnosed with mental health needs and developmental disabilities.
- Arkansas has almost no capacity to treat substance abuse disorders among adolescents.
- There is a lack of qualified professional staff, both in rural settings and for several types of mental health specialties (e.g., child-trained psychiatrists).
- Some stakeholders perceive that certain providers decide what services to provide by what can be paid through Medicaid (RSPMI), rather than by what children and families need.
- Generally speaking, higher education institutions in Arkansas are not involved in a planned effort to prepare persons to work in a mental health system-of-care approach.
- The Licensed Professional Counselor Board has not established reciprocity agreements with other states, hindering recruitment of out-of-state, licensed professionals to work in Arkansas.

3) **Recommended strategies to develop the mental health workforce:**

- ❖ Statewide training in the system-of-care approach to care of children and families;
- ❖ Establish a Psychiatric Services Development Committee to guide Arkansas professional training programs toward better preparation of staff in the System of Care model of care for children and families;
- ❖ Develop standardized pre-service training for all staff entering the publicly-funded helping systems;
- ❖ Promote and develop telemedicine capacities in rural Arkansas communities; and
- ❖ Explore and develop multi-cultural, bi-lingual treatment capacities, where appropriate to the population of children in need of mental health care.

E. Enhance linkages with physicians and early childhood providers. *Arkansas will develop partnerships among parents, early childhood care and education providers, and primary care physicians to assure that: 1) all children are enrolled with a primary care physician; 2) all parents are aware of the value of regular doctor visits for their children and the importance of preventive measures, such as developmental screenings that include behavioral health screening; and, 3) all parents are aware of the importance of their active participation with their primary care physician in the provision of physical and behavioral health care for their children.*

1) System of Care Rationale

One of the most valuable tenets of the system-of-care approach is the emphasis on early identification and intervention, recognizing that it is possible to identify emerging mental health needs fairly early in a child's development. When such needs are recognized it is also possible to intervene in ways that move that child back towards a more normative developmental trajectory. Gains in understanding of serious emotional disturbances during the past two decades have led to an increased ability to recognize precursors of serious disturbances and to intervene effectively to prevent the development of the more serious disturbances. Parents are increasingly recognized as valid assessors of their child's capabilities, providing signals for professionals to identify needs and craft effective

intervention strategies. Partnerships between mental health professionals, day care providers, and family physicians (including pediatricians) promote early recognition of emerging needs. Early interventions have become more family and community based, much more readily available, are shown to be less costly, and are ultimately more effective.

2) Why This is a Priority for Arkansas

- Family physicians and pediatricians have been developing the concept of a "medical home" for children over the past several years, supported in part by a grant to the Pediatric Department of the University of Arkansas for Medical Sciences. Residents in Family Medicine and Pediatrics are trained in the concepts of a medical home, including the importance of seeking services that are comprehensive, community based, culturally appropriate and family centered, all central tenets in the system-of-care approach.
- A strong collaboration between DBHS, the Division of Child Care and Early Childhood Education, and the University of Arkansas for Medical Sciences is developing and evaluating models of early childhood mental health care, in conjunction with day care and Head Start programming.
- Many Arkansas primary care physicians are unaware of effective, simple and quick tools that can be used to identify emotional disturbances in young children.
- Few family physicians, pediatricians, or day care providers utilize comprehensive developmental screening tools, in part because none are trained to utilize such tools.
- Many physicians and day care providers are unaware of the service resources available to the families they serve, when needs are identified.
- Few Arkansas schools have active, functional relationships with providers of mental health care for children and families.
- Linkages between the publicly funded service systems and physicians and day care providers are almost nonexistent, leading to very low numbers of referrals from those best able to identify needs to those best able to respond to such needs.

3) **Recommended strategies to enhance linkages with physicians and early childhood providers:**

- ❖ Establish an Early Child Workgroup to design and implement mechanisms to educate early childhood care providers about mental health needs and care approaches;
- ❖ Continue promotion of Primary Care Physician medical home practices;
- ❖ Train mental health professionals regarding early childhood practices;
- ❖ Expand current school-based mental health programs to younger grades;
- ❖ Expand mental health components of the EPSDT screen; and
- ❖ Educate the public about early childhood mental health needs and care approaches.